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ABSTRACT

The Social Skills Development Program (SSDP) is a prevention program for inner-city primary-age school children. The services provided by SSDP are for children experiencing moderate school maladjustment. Included are descriptions of program rationale and operations, staffing, prescriptive early intervention, preventive health interventions and problems of implementation. The problems identified for discussion are: (1) how to reverse patterns of life-style that contribute to chronic poor health: (2) how involvement with the child should continue in the absence of parent participation: (3) how to procure positive results with transient families: and (4) how to balance national priorities and local politics. Although the program is geographically specific, it can be adapted for use in elementary schools elsewhere. (Author/BMW)

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PRESCRIPTIVE EARLY INTERVENTION WITH CULTURALLY DIVERSE POPULATIONS: SOME INITIAL OBSERVATIONS

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PRESCRIPTIVE EARLY INTERVENTION WITH CULTURALLY DIVERSE POPULATIONS: SOME INITIAL OBSERVATIONS

The Social Skills Development Program (SSDP) is a unique secondary prevention program for inner-city primary age school children, which functions under the auspices of the Cincinnati Health Department. The historical roots of the program can be traced back five years when a former Assistant Commissioner of Mental Health implemented the Primary Mental Health Project model (Cowen, et al., 1975) within one school in the Cincinnati Public School System. Services are now provided in seven elementary schools to children experiencing moderate school maladjustment.

In the remainder of this paper we plan to address issues of (a) program rationale and operations, (b) staffing, (c) prescriptive early intervention in practice, (d) preventive health interventions and (e) problems of implementation.

PROGRAM RATIONALE AND OPERATIONS

Following from the Glidewell and Swallow (1969) survey, three out of ten primary grade school children manifest significant social adjustment problems. SSDP attempts to identify and intervene early in the school adjustment problems of such targeted children. Focusing primarily on grades K-3, SSDP staff conducts mass screening teacher interviews in each school to identify "high risk" children with lower teacher-assessed social competencies. After a thorough assessment, behavioral goals and a prescriptive therapeutic plan are established. Services are typically rendered via structured small group and individual sessions for one hour twice a week. The

program is based on a social competence model, fortifying children with specific interpersonal skills such as social problem-solving, differentiation of feelings, self management, and enhanced self-esteem.

An operating value of all components of the SSDP is the efficacy of prescriptive early intervention. Although the value of and model for prescriptive psychotherapeutic interventions has been well documented (Goldstein & Stein, 1976) there remains a dearth of literature applying this strategy to early intervention. SSDP staff systematically attempt to provide "tailor-made interventions" with culturally diverse populations. Thus, we conceptually and operationally challenge the uniformity myth (Keisler 1966) that one set of therapeutic interventions can be applied with equal efficacy to all clients regardless of ethnic and cultural differences. In the following paragraph(s) we would like to further elucidate the Social Skills Development Program as an example of prescriptive early intervention.

STAFFING

Each of the seven schools are staffed with a full time team including a Master's level team leader, and two to three para-professionals. Additional paid part-time para-professionals, and graduate students compliment the full time staff in each of the Early Periodic Screening Diagnosis and Treatment (EPSDT) demonstration schools and the LEAA demonstration schools. The "school specialists" conduct social skill enhancement sessions with identified children and consult with primary grade teachers. A second

cadre of "community specialists" have primary responsibility for structured health assessments, follow-up, and parent education and intervention. This staffing pattern has the obvious advantages that specialization brings, (e.g. clear lines of responsibility and authority, more thorough knowledge of a delimited area), and avoids problems of matrix organizations (Davis & Lawrence, 1978).

PRESCRIPTIVE EARLY INTERVENTION IN PRACTICE

During the course of SSDP's five years of operation several clinical observations relevant to prescriptive early intervention have been made. Within the following section the authors will describe different cultures of children seen in the program and articulate clinical observations and corresponding interventions. The first such anecdotal observation of school adjustment problems presented by our clients is the difference in presenting problems of Black children at two demonstration schools and Appalachian children at two other demonstration schools. There appears to be a characteristic pattern of dependency in mother-child relationships among the Appalachian population not typically found among the Afro-American population. Concommitant with this interdependent mother-child relationship is a fear and distrust of strangers and public institutions. This is manifest in observed problems of school phobia, absenteeism, and reticence to communicate with peers and adults in school settings. For an example, one teacher remarked about a particulary withdrawn child that she seemed almost "invisible".

As a result of the clinical-cultural picture articulated above,

our intervention modality with this group involves pairing two children with one SSDP staff member for two one-hour-weekly sessions. This is in contrast to our general policy of seeing children in groups of four or five. In the former case a very withdrawn child would be paired with a more verbally expressive child. The goal of such placement is for the withdrawn child to model the behavior of the more expressive child, and develop assertive skills.

One salient feature of intervention with children referred from predominantly Afro-American Schools is the teaching of cultural and ethnic identity (Jackson, 1976; Smith et al 1978). The rationale for this intervention is the high number of students referred for low self-esteem. Afro-American social scientists have long recommended the teaching of ethnic identity and cultural history to combat perceived low self-esteem of Afro-American clients and children. Cultural alienation and oppression also may lead to perceived low self-esteem in many Afro-Americans. Recognizing a similar need for enhancing the self-esteem of children from the predominantly Appalachian school SSDP staff attempt to intervene on an individual level through identifying the individual strengths of the referred children. Thus with both types of children enhancing social competence and self-esteem are the foci of SSDP interventions: it is only the method that differs. Since many of the children at the predominantly Afro-American schools are referred for classroom disruptive behavior (name calling, fighting, talking out of turn) the small group setting is a natural mini-laboratory for teaching interpersonal and social-problem-solving skills. While such behaviors are indeed deemed disruptive in the classroom setting

they may well be reinforced and have strong survival value in many segments of local Afro-American communities.

PREVENTIVE HEALTH INTERVENTION

The rationale for the EPSDT component of the SSDP program and hence for the inclusion of this section can be traced back to the 1976 report by the Office of Child Health Affairs on health status of poor children (OCHA). Low income children suffer disproportionality higher incidence and prevalence of health problems. In addition to these national observations, prior to the addition of this medical component, SSDP staff observed that many children referred to them had chronic health problems. Even when there were neighborhood health clinics available, families apparently did not make systematic use of them. With the advent of SSDP's application for and award of EPSDT funds, we now provide thorough physical assessment. Special prescriptive health services provided by SSDP-EPSDT staff will be described in greater detail.

PROBLEMS

Differences between Afro-American and Appalachian populations have been supported by clinical impressions. However, isolating specific behaviors and situational parameters proved to be very challenging. The authors recognize the potential dangers of cultural categorization. Our purpose is not to render absolute stereotypic conclusions regarding cultural differences. Matching intervention strategies to specific presenting problems is our goal. Heeding this caveat, the authors proceeded cautiously to identify 1) client differences among our four school populations, and 2) individually suited interventions.

The four problems identified for presentation here are: (1) How to reverse patterns of life-style that contribute to chronic poor health, (2) how and if involvement with the child should continue in the absence of parent participation, (3) how to procure positive results with transient families, and (4) how to promote prevention versus crisis intervention or how to balance national priorities and local politics.

Implementing a prescriptive program of this scope demands confrontation of entrenched problems and the development of effective solutions. One of the most persisting problems faced by our community specialist staff are patterns of life style that contribute to chronic poor health. Inadequate nutrition and delayed action on acute health problems are part of this cycle. Reversing these patterns is a tremendous staff challenge. Parent education groups, specifically geared to member's needs is one mode of intervention. Another important intervention is teaching parents how to negotiate in the medical system i.e., how to seek out specialist services and providing information about rights and eligibility requirements.

A second challenge which we face is how to secure active parent involvement when providing counseling and health services to their children. Recognizing the wisdom of fostering independence and self-sufficiency within families, we want to provide services to children without usurping the parent's primary responsibility. The provocative question remains: how, and if involvement with a child should continue in the absence of parent participation. Realizing the multiple demands on some families, especially those with single parents, our goal is to support and assist them with the responsi-

bilities of child rearing, not to do it for them.

The third, and most frustrating problem for SSDP staff is the frequent mobility of the families it serves. Often, just as relationships are established, and there are beginning signs of progress, families move away. They may later return, as is often seen in the Appalachian Community, with the same presenting problems. Staff again becomes involved, hoping the family will this time be located long enough to benefit.

A fourth problem we struggle with is the issue of prevention versus crisis intervention. SSDP is based on a preventive philosophy and staff is trained to provide early intervention in schools with many tertiary care needs. The political ramifications are obvious. There is sometimes pressure on SSDP staff to respond to children with severe behavior problems now, and preventive intervention is regarded as a luxury. This issue is one that generalizes to differences between national priorities, and local politics. The National Institute of Mental Health supports and advocated programs devoted to the prevention of emotional and health problems. Local agencies are still flooded to stomp out, rather than prevent fires, and faced with political and fiscal repercussions.

In conclusion a number of complex and diverse problems attend the successful and continuous implementation of this program. However, based upon our impressions, prescriptive, early interventions offer much promise to the future of preventive efforts.

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